Senate Bill 572

By: Senators Goggans of the 7th, Stephens of the 27th, Williams of the 19th, Douglas of the 17th, Pearson of the 51st and others

AS PASSED

AN ACT

To amend Article 7 of Chapter 4 of Title 49 of the Official Code of Georgia Annotated, relating to medical assistance generally, so as to change certain provisions relating to unlawful acts regarding Medicaid; to provide for inclusion of medical assistance managed care fraud; to change certain provisions relating to administrative hearings and appeals; to provide for hearings on disputed payments before an administrative law judge; to provide for procedure related to such hearings, including assessment of costs; to require legislative notification for the submission of certain waivers pursuant to Section 1115 of the federal Social Security Act; to provide for a limit on the effective date of the Medicaid estate recovery program; to provide for substantial and unreasonable hardship waivers on any claim against the first $100,000.00 of any homestead; to provide for notice requirements; to provide for installment payments; to provide for submission of an amendment to the state plan; to provide for related matters; to provide for an effective date; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Article 7 of Chapter 4 of Title 49 of the Official Code of Georgia, relating to medical assistance generally, is amended by adding a new Code section to read as follows:

"49-4-142.1.

On and after the effective date of this Code section, neither the department, the board, nor any other representative of the state shall submit any request to the United States Department of Health and Human Services Centers for Medicare and Medicaid Services for a waiver pursuant to Section 1115 of the federal Social Security Act without legislative notification. This shall apply only to waivers that relate to Medicaid modernization, Medicaid transformation, or a Medicaid reform model that would affect 20,000 or more individuals in the Georgia Medicaid population. The legislative notification required under

this Code section shall be by Act of the General Assembly or the adoption of a joint resolution of the General Assembly."

SECTION 2.

Said article is further amended striking subsections (a) and (b) of Code Section 49-4-146.1, relating to unlawful acts regarding Medicaid, and inserting in lieu thereof new subsections (a), (b), and (i) to read as follows:

"(a) As used in this Code section, the term:

(1) 'Agent' means any person who has been delegated the authority to obligate or act on behalf of a provider.

(2) 'Convicted' means that a judgment of conviction has been entered by any federal, state, or other court, regardless of whether an appeal from that judgment is pending.

(3) 'Indirect ownership interest' means any ownership interest in an entity that has an ownership interest in the provider entity. The term includes an ownership interest in any entity that has an indirect ownership interest in the provider entity.

(4) 'Managing employee' means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the institution, organization, or agency.

(5) 'Payment' includes a payment or approval for payment, any portion of which is paid by the Georgia Medicaid program, or by a contractor, subcontractor, or agent for the Georgia Medicaid program pursuant to a managed care program operated, funded, or reimbursed by the Georgia Medicaid program.

(6) 'Person' means any person, firm, corporation, partnership, or other entity.

(7) 'Person with an ownership or control interest' means a person who:

(A) Has ownership interest totaling 5 percent or more in a provider;

(B) Has an indirect ownership interest equal to 5 percent or more in a provider;

(C) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a provider;

(D) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the provider entity if that interest equals at least 5 percent of the value of the property or assets of the provider;

(E) Is an officer or director of a provider that is organized as a corporation; or

(F) Is a partner in a provider entity that is organized as a partnership.

(8) 'Provider' means an actual or prospective provider of medical assistance under this chapter. The term 'provider' shall also include any managed care organization providing services pursuant to a managed care program operated, funded, or reimbursed by the Georgia Medicaid program.

(b) It shall be unlawful:

(1) For any person or provider to obtain, attempt to obtain, or retain for himself, herself, or any other person any medical assistance or other benefits or payments under this article, or under a managed care program operated, funded, or reimbursed by the Georgia Medicaid program, to which the person or provider is not entitled, or in an amount greater than that to which the person or provider is entitled, when the assistance, benefit, or payment is obtained, attempted to be obtained, or retained, by:

(A) Knowingly and willfully making a false statement or false representation;

(B) Deliberate concealment of any material fact; or

(C) Any fraudulent scheme or device; or

(2) For any person or provider knowingly and willfully to accept medical assistance payments to which he or she is not entitled or in an amount greater than that to which he or she is entitled, or knowingly and willfully to falsify any report or document required under this article.″

″(i) It shall be the duty of the department to identify and investigate violations of this article and to turn over to the prosecuting attorney, for prosecution, any information concerning any recipient of medical assistance who violates this article.″

SECTION 3.

Said article is further amended by striking Code Section 49-4-147.1, relating to claims by the department against the estate of Medicaid recipients, and inserting in lieu thereof the following:

″49-4-147.1.

(a) In accordance with applicable federal law and regulations, including those under Title XIX of the federal Social Security Act, the department may make claim against the estate of a Medicaid recipient for the amount of any medical assistance payments made on such person´s behalf by the department. A claim shall be made against the estate of a deceased Medicaid recipient only if at the time of application for medical assistance the applicant received written notice that the medical assistance costs could be recovered from the applicant´s estate and the applicant signed a written acknowledgment of receipt of such

notice, the estate is otherwise subject to recovery, if no hardship or other exemption exists. The commissioner shall waive such claim if he or she determines enforcement of the claim would result in substantial and unreasonable hardship to dependents of the individual against whose estate the claim exists.

(b) The estate recovery program established pursuant to this Code section shall not be effective any earlier than the effective date of this subsection. In no event shall the department make claims against the estate of a Medicaid recipient for the amount of any medical assistance payments made on such person´s behalf prior to the effective date of this subsection.

(c) The commissioner shall delay execution of a claim against the estate where the dependents or heirs agree to pay the full amount of the claim in reasonable installments.

(d) To prevent substantial and unreasonable hardship, the commissioner shall waive any claim against the first $100,000.00 of any estate. The commissioner shall annually adjust this exemption based on changes in the consumer price index. The value of the estate shall not include year´s support, funeral expenses not to exceed $5,000.00, necessary expenses of administration, or reasonable expenses of the recipient´s last illness. No later than July 1, 2006, the department shall submit an amendment to the state plan with the United States Department of Health and Human Services Centers for Medicare and Medicaid Services reflecting the provisions of this subsection. In the event that such amended state plan is not approved, this subsection shall stand repealed in its entirety.″

SECTION 4.

Said article is further amended in Code Section 49-4-153, relating to administrative hearings and appeals, judicial review, and contested cases involving imposition of remedial or punitive measures against a nursing facility, by striking subsection (b) and inserting in lieu thereof the following:

″(b)(1) Any applicant for medical assistance whose application is denied or is not acted upon with reasonable promptness and any recipient of medical assistance aggrieved by the action or inaction of the Department of Community Health as to any medical or remedial care or service which such recipient alleges should be reimbursed under the terms of the state plan which was in effect on the date on which such care or service was rendered or is sought to be rendered shall be entitled to a hearing upon his or her request for such in writing and in accordance with the applicable rules and regulations of the department and the Office of State Administrative Hearings. As a result of the written

request for hearing, a written recommendation shall be rendered in writing by the administrative law judge assigned to hear the matter. Should a decision be adverse to a party and should a party desire to appeal that decision, the party must file a request in writing to the commissioner or the commissioner´s designated representative within 30 days of his or her receipt of the hearing decision. The commissioner, or the commissioner´s designated representative, has 30 days from the receipt of the request for appeal to affirm, modify, or reverse the decision appealed from. A final decision or order adverse to a party, other than the agency, in a contested case shall be in writing or stated in the record. A final decision shall include findings of fact and conclusions of law, separately stated, and the effective date of the decision or order. Findings of fact shall be accompanied by a concise and explicit statement of the underlying facts supporting the findings. Each agency shall maintain a properly indexed file of all decisions in contested cases, which file shall be open for public inspection except those expressly made confidential or privileged by statute. If the commissioner fails to issue a decision, the initial recommended decision shall become the final administrative decision of the commissioner.

(2)(A) A provider of medical assistance may request a hearing on a decision of the Department of Community Health with respect to a denial or nonpayment of or the determination of the amount of reimbursement paid or payable to such provider on a certain item of medical or remedial care of service rendered by such provider by filing a written request for a hearing in accordance with Code Sections 50-13-13 and 50-13-15 with the Department of Community Health. The Department of Community Health shall, within 15 business days of receiving the request for hearing from the provider, transmit a copy of the provider´s request for hearing to the Office of State Administrative Hearings. The provider´s request for hearing shall identify the issues under appeal and specify the relief requested by the provider. The request for hearing shall be filed no later than 15 business days after the provider of medical assistance receives the decision of the Department of Community Health which is the basis for the appeal.

(B) The Office of State Administrative Hearings shall assign an administrative law judge to hear the dispute within 15 days after receiving the request. The hearing is required to commence no later than 90 days after the assignment of the case to an administrative law judge, and the administrative law judge shall issue a written decision on the matter no later than 30 days after the close of the record except when it is

determined that the complexity of the issues and the length of the record require an extension of these periods and an order is issued by an administrative law judge so providing, but no longer than 30 days. Such time requirements can be extended by written consent of all the parties. Failure of the administrative law judge to comply with the above time deadlines shall not render the case moot.

(C) A request for hearing by a nursing home provider shall stay any recovery or recoupment action.

(D) Should the decision of the administrative law judge be adverse to a party and should a party desire to appeal that decision, the party must file a request therefor, in writing, with the commissioner within ten days of his or her receipt of the hearing decision. Such a request must enumerate all factual and legal errors alleged by the party. The commissioner, or the commissioner´s designated representative, may affirm, modify, or reverse the decision appealed from.

(3) A person or institution who either has been refused enrollment as a provider in the state plan or has been terminated as a provider by the Department of Community Health shall be entitled to a hearing; provided, however, that no entitlement to a hearing before the department shall lie for refusals or terminations based on the want of any license, permit, certificate, approval, registration, charter, or other form of permission issued by an entity other than the Department of Community Health, which form of permission is required by law either to render care or to receive medical assistance in which federal financial participation is available. The final determination (subject to judicial review, if any) of such an entity denying issuance of such a form of permission shall be binding on and unreviewable by the Department of Community Health. In cases where an entitlement to a hearing before the Department of Community Health, pursuant to this paragraph, lies, the Department of Community Health shall give written notice of either the denial of enrollment or termination from enrollment to the affected person or institution; and such notice shall include the reasons of the Department of Community Health for denial or termination. Should such a person or institution desire to contest the initial decision of the Department of Community Health, he or she must give written notice of his or her appeal to the commissioner of community health within ten days after the date on which the notice of denial or notice of termination was transmitted to him or her. A hearing shall be scheduled and commenced within 20 days after the date on which the commissioner receives the notice of appeal; and the commissioner or his or her designee or designees shall render a final administrative decision as soon as practicable thereafter.″

SECTION 5.

Said article is further amended in Code Section 49-4-153, relating to administrative hearings and appeals, judicial review, and contested cases involving imposition of remedial or punitive measures against a nursing facility, by adding a new subsection (e) to read as follows:

"(e)(1) A provider of medical assistance may request a hearing on a decision of a care management organization with respect to a denial or nonpayment of or the determination of the amount of reimbursement paid or payable to such provider on a certain item of medical or remedial care of service rendered by such provider by filing a written request for a hearing in accordance with Code Sections 50-13-13 and 50-13-15 with the Department of Community Health. The Department of Community Health shall, within 15 business days of receiving the request for hearing from the provider, transmit a copy of the provider´s request for hearing to the Office of State Administrative Hearings, but shall not be a party to the proceedings. The provider´s request for hearing shall identify the care management organization with which the provider has a dispute, the issues under appeal, and specify the relief requested by the provider. The request for hearing shall be filed no later than 15 business days after the provider of medical assistance receives the decision of the care management organization which is the basis for the appeal.

(2) The Office of State Administrative Hearings shall assign an administrative law judge to hear the dispute within 15 days after receiving the request. The hearing is required to commence no later than 90 days after the assignment of the case to an administrative law judge, and the administrative law judge shall issue a written decision on the matter no later than 30 days after the close of the record except when it is determined that the complexity of the issues and the length of the record require an extension of these periods and an order is issued by an administrative law judge so providing, but no longer than 30 days. Such time requirements can be extended by written consent of all the parties. Failure of the administrative law judge to comply with the above time deadlines shall not render the case moot.

(3) The decision of the administrative law judge shall be the final administrative remedy available to the provider. Review thereafter shall proceed in accordance with Code Section 50-13-19. The fees and expenses of the Office of State Administrative Hearings may, at the administrative law judge´s discretion, be assessed against the party against whom the administrative law judge enters his or her order."

SECTION 6.

This Act shall become effective on April 1, 2006, or upon its approval by the Governor, whichever last occurs, or upon its becoming law without such approval.

SECTION 7.

All laws and parts of laws in conflict with this Act are repealed.